

DATE: June 19, 1997

DSL-BQA-97-015

TO: Community Based Residential Facilities

CBRF 06

FROM: Judy Fryback, Director
Bureau of Quality Assurance

SUBJECT: (1) Use of Physical Restraints; (2) Correction to DSL-2372 CBRF Resident Satisfaction Evaluation

OVERVIEW: (1) This memo describes the Department's position on restraint use and the conditions that must be met before Departmental approval will be given to physically restrain a CBRF resident. This memo includes a quick-reference brochure on restraint use and answers to the questions on restraints that arose during the HFS 83 training sessions held from October through December 1996. (2) In addition, this memo conveys a [new copy of DSL-2372](#), CBRF Resident Satisfaction Evaluation. This copy should replace the one that was sent on February 17, 1997 in memo [DSL-BQA-97-004](#).

RESTRAINTS: It is the Department's position that physical and chemical restraint use with residents of any health-care provider should be the exception rather than the rule. Physical restraints are not benign devices that keep residents free from injury; instead, current research shows that residents in restraints are **three times more likely** to suffer serious injury than those who are not restrained.

HFS 83.21(4)(n)4a gives each CBRF resident the right to "be free from physical restraints except upon prior review and approval by the department and upon written authorization from the resident's primary physician. The department may place conditions on the use of a restraint to protect the health, safety, welfare and rights of the resident." If a physician has authorized in writing the use of a restraint, the department will approve its use only if:

- the restraint is medically necessary, i.e., it benefits the resident and allows the resident to attain or maintain his/her highest possible level of independent functioning;
- the resident has a medical symptom/need, identified in the resident's assessment, that will be treated by the restraint. Falls and problem behaviors such as combativeness or wandering are **not** medical symptoms but are manifestations of an underlying condition (e.g., environmental stressors, psychosocial stressors, infections, etc.);
- staff have properly assessed the *underlying condition* and the need for the restraint;
- staff have considered, and used, alternative methods for care and/or managing resident behavior without success (i.e., an individualized assessment and service plan for managing behaviors has not been successful);
- the proposed restraint is the least restrictive device;
- staff are not using the restraint for discipline, as a means of punishing, penalizing, or restricting a resident;
- staff are not using the restraint for convenience, which means that the restraint is not being used in lieu of sufficient staff or awake staff or to enable staff to carry out other duties;
- staff have been trained regarding what restraint to use, how to use it, and when to use it. [HFS 83.21(4)(n)4b states that "only resident care staff trained in the proper use of the restraint may apply the restraint to the resident."];
- the restraint is used only during the time it is needed and documentation is maintained each time the restraint is used, as required at HFS 83.21(4)(n)4c; and

- the resident and/or legal representative has been informed of the risks/benefits of restraint use and has approved the restraint.

To request departmental approval, please send the following to your Regional Field Operations Director:

- (1) the resident's name,
- (2) a copy of the physician's restraint order, which identifies the type of restraint and the time period for its application,
- (3) the reason for the restraint (summarize your assessment and identify the medical symptom being treated by the restraint),
- (4) the alternatives that were tried,
- (5) signed consent by the resident/legal representative to use the restraint, and
- (6) information showing that staff have been trained to properly use and apply the restraint.

As a reminder, a physical restraint is confinement to a locked room or any manual method (e.g., pushing a resident close to a table) or any article, device or garment that interferes with:

- free movement of the resident, or
- normal functioning of a portion of the body, or
- normal access to a portion of the body, **and** which
- the individual is unable to remove easily.

We are including a quick-reference brochure which summarizes the Department's position on physical restraint use in a community-based residential facility. In addition, we are attaching our responses to all the questions related to physical restraints that arose during the industry training on HFS 83.

DSL-2372, CBRF RESIDENT SATISFACTION EVALUATION: On February 17, 1997, we sent a memo [DSL-BQA-97-004](#) with copies of a number of forms to be used in CBRFs. We were not aware that a printing error had occurred on one of those forms. As a result, we ask that you replace the form entitled "[Community Based Residential Care Facility \(CBRF\) Resident Satisfaction Evaluation](#)" (DSL-2372) with the copy that is enclosed with this memo. You may reproduce this form as needed.

If you have additional questions regarding the issues contained in this memo, please contact the Regional Field Operations Director assigned to your region. Their phone numbers are as follows:

Northeastern/Green Bay Regional Office:	Pat Benesh	414-448-5249
Northern/Rhineland Regional Office:	Joe Bronner	715-365-2500
Southern/Madison Regional Office:	Phyllis Tschumper	608-243-2374
Southeastern/Milwaukee Regional Office:	Tony Oberbrunner	414-227-4908
Western/Eau Claire Regional Office:	Charles Kirk	715-836-4753

RESTRAINT QUESTIONS AND ANSWERS

EFFECTIVE DATE

1. Is the restraint requirement effective January 1997 or January 1998? This seems to be a reason for N.H. placement since CBRFs won't want to deal with the "paperwork" connected to this issue. It appears we will be as regulated as N.Hs!

A. *The need for Department approval for the use of physical restraints went into effect on January 1, 1997.*

DEFINITIONS OF A RESTRAINT

2. Are railings on a bed (like a hospital bed) considered a restraint that requires departmental approval?

A. *Side rails are considered a restraint if the device interferes with the free movement of the resident, normal functioning of a portion of the body, or normal access to a portion of the body and the device can not be easily removed by the resident. Railings on a bed usually meet the definition of a physical restraint.*
3. Are soft, mesh siderails considered a restraint and are metal half siderails considered a restraint?

A. *They may be, if they restrict free movement of the resident, as explained in the answer to question number 2.*
4. Will restraint definitions be the same as for long term care facilities? Example 1: Wedge cushion in a wheelchair; if the client is unable to get out of the chair without assistance, would this be a restraint? Example 2: If a resident has a diagnosis of multi-infarct dementia, or Alzheimer's dementia, and has an antipsychotic ordered for unpredictable behavior, would this be considered a restraint?

A. *The restraint definitions for CBRFs are not the "same" as for long term care facilities; however, the language is somewhat similar (see Section HFS 83.21(4)(n)a., b., c.). Response to example 1: Yes, the wedge cushion would be considered a restraint in that situation because it prevents the resident from rising. Response to example 2: The medical literature contains references that antipsychotics work well in psychotic situations. The literature does not support the same success with dementias. If the person has dementia with psychotic features (hallucinations, paranoia, aggressions) that are affecting the functional capacity of the resident, then small doses have had some success. The medications are not indicated for yelling, wandering, or other non-psychotic behaviors. This medication would be considered a chemical restraint if there were no psychotic symptoms or indications for use, the resident or representative is not involved in setting ISP (individual service plan) goals, there is no behavior monitoring, and there is no assessment for other causes of the behavior.*
5. If a resident is asked to leave an activity or meal because their behavior is not acceptable, is this a restraint because of isolation to the room?

A. *Not if the room is unlocked and the resident can independently leave the room on his/her own.*
6. Does using a lap belt (seat belt) to restrict movement, access to the body or normal body position, where the resident can not remove lap belt, meet the definition of a restraint and would this need Departmental approval? This is a facility policy to use lap belts.

A. *We recommend that you re-examine your facility's "policy." Any blanket policy that requires seat belts does not seem to allow for an individualized assessment of each resident. The goal here is that unnecessary restraints that do not treat a medical condition are eliminated. Anything that meets the definition of a restraint in HFS 83 is considered a restraint and must be ordered by a physician and approved by the Department.*

7. The Community Integration Program (CIP) specialist is interpreting the use of a gait belt as a restraint. Does the new code address this issue? (The same with hospital bed rails, motion sensors, etc.)
 - A. *You need to review the definition of a physical restraint in Section HFS 83.21(4)(n)1.c. A restraint means any manual method or any article, device or garment interfering with free movement of the resident or the normal functioning of a portion of the body and which the individual is unable to remove easily. A motion sensor would not be considered a restraint unless it activates/closes a door. It would be difficult to define a gait belt as being a restraint. However the resident assessment for a gait belt should indicate its reason for use.*
8. Is there a written definition of when "positioning" items (pads, wedges, rolls, etc.) become physical restraints?
 - A. *A positioning device may or may not be a physical restraint, depending whether it meets the definition of a restraint in HFS 83.21(4)(n). If something meets the HFS 83 definition of a restraint, it is a restraint.*
9. If the wheels on a bed are removed because a resident is short, is this a restraint? Lowering the bed is mentioned, but this helps the resident.
 - A. *Removing the wheels on a bed would not be considered a restraint. In fact, lowering the bed may be a way to eliminate the need for a restraint.*
10. Do restraints include a self-releasing belt attached to a wheel chair?
 - A. *If the resident cannot easily self-release the belt, it is considered a restraint.*
11. Does staff performing a standing basket hold on a resident, to prevent that resident from striking another person, constitute a restraint?
 - A. *Yes. The above intervention must be included in the individual service plan. This use of physical restraint requires Departmental approval.*
12. Is an "alert guard bracelet" for a resident who wanders considered a restraint?
 - A. *No.*
13. Are helmets to protect a resident's head considered restraint? (i.e.-seizure client, seizures unable to be predicted, client experiencing frequent seizures with inability to catch self before falling has seen numerous neurologists but unable to stabilize seizures, One seizure medication?)
 - A. *If the helmet interferes with the free movement of the resident or prevents normal access to a portion of the resident's body, it would be considered a restraint. This would be ascertained by the assessment for the use of a helmet.*
14. Please explain why using a recliner with a stool under the foot rest so that the resident cannot put the foot rest down is not a restraint.

- A. *It is a restraint if it meets the definition in HFS 83.21(4)(n)1.c. It may also be the least restrictive restraint for a particular resident. Based on resident assessment, you may want to provide an alarm that will signal that the resident is attempting to leave the chair and needs assistance. This use of an alarm would not be considered a restraint.*

DEPARTMENTAL APPROVAL

15. Does Department approval for restraints include bed rails?

- A. *Yes if the bed rails meet the definition of a restraint in HFS 83.21(4)(n)1.c. If the resident can remove the bed rail and it is not restricting movement or access to his/her body, then it is not a restraint.*

16. Are 1/2 side rails considered a restraint and do you need prior approval from the state to use them? What if the resident has one rail up against a wall. Do we need prior approval for this?

- A. *1/2 side rails are not considered a restraint if the resident can put the rail down and get out of bed or independently get out of bed with the rail up. You would not need prior approval from the Department. If the resident has one rail up against a wall, the need for prior Departmental approval would depend on the assessment of this individual. If the resident's ability to leave the bed is not inhibited or restricted, then this might not be a restraint. Again, it depends on the resident assessment.*

17. Does a restraint request for approval and physician order include: 1) belts used for wheelchairs if the resident is unable to position him/herself; 2) belt is used in wheelchair during transport due to seizure disorder; and 3) belt is used for toileting a client who has a severe seizure disorder (physician has supplied order to use).

- A. *There is no differentiation of the definition of restraints according to the resident's diagnosis or physical or mental condition. The HFS 83 definition needs to be applied and the resident assessed accordingly. Ask the questions step by step that are in HFS 83.21(4)(n)1.c. Restraints used in conjunction with toileting are very dangerous. A physician's order alone is not sufficient for the use. Restraints used for toileting purposes are not likely to be approved by the Department due to their high degree of danger. They are not to be used in lieu of having a staff person nearby to aid the resident should the resident require assistance while on the toilet.*

18. If a hospice resident is terminally ill at a CBRF and the plan requires physical restraints, would the procedure be the same for obtaining state approval? Does the hospice's treatment plan for restraints supersede the CBRF restraint requirements?

- A. *In the current hospice requirements, there is no reference to obtaining approval for restraints; therefore, HFS 83 requirements would take precedence and Department approval is required. The hospice must be in compliance with Chapter HSS 131 and the CBRF is responsible for compliance with Chapter HFS 83. The hospice requirements take precedence over the CBRF requirements when there is a conflict.*

19. Are physical restraints/holds used by staff, who were trained in nonviolent crisis intervention, allowed as a **last** resort?

- A. *They should be submitted to the Department for approval as a physical restraint. These restraints need to be included as part of the individual service plan.*

20. Our facility does not use any type of manual restraints (i.e. straps, ropes). However we do use physical restraints by staff. For example, staff will "hold" an individual in accordance with the techniques taught by the national crisis institute. Do we need departmental approval and doctor's orders to perform this type of nonviolent crisis intervention?
- A. *The holds used on residents need to be part of the individual service plan and need to be approved by the Department. Physical restraints require a physician order. In a true, nonpredictable emergency, prior Department approval is not needed. However, any repetition may well be predictable and requires prior Department approval.*

CHEMICAL RESTRAINTS

21. Would a reference to chemical restraints to alleviate psychological symptoms from an ongoing diagnosis, such as manic depression, require approval by the Department to give PRN when following physicians orders/parameters for use?
- A. *When a psychoactive medication is used for a medical diagnosis and is being properly managed by the attending physician, it is not considered a chemical restraint. Departmental approval is not required. If a person has manic depression, a PRN (as needed) medication would not generally be indicated. It takes a certain blood level to control this disease, and this cannot be achieved with PRN dosing. A PRN dose may be indicated to increase the dose of a routine medication (the resident is already on) because of cyclic changes in the disease.*
22. Under restraints, is approval needed for medications used only to calm an individual for a medical appointment?
- A. *No. Such medications are treating a medical symptom, i.e., to allow a necessary medical examination/treatment.*
23. With regard to chemical restraints: We have a resident who, for many years, has had a prescription from her physician for an anti-anxiety medication (long before entering our CBRF). The doctor refuses to provide a diagnosis and the resident and family disagree.
- A. *The following interventions have worked successfully in other health care settings. (1) Have the family ask the physician why the resident is taking the medication. No medication should be prescribed without the PRESCRIBER informing the patient what the medication is being used for and what the expected benefits and risks are. (2) Contact the pharmacist, as the regulations now require the pharmacist to ask the customer what the medication is being used for. (3) Write a letter to the county/state medical society asking for advice on how to address this concern.*
24. If medications are needed, and approved, and dosages are changed, does that need to be re-approved?
- A. *Approval is not required for the use of psychoactive medications.*

SAFETY ISSUES

25. How might you respond to a family who firmly insists on restraints for a resident who moves about only occasionally, but then may fall? Family threatens "you can do all that other stuff (suggested interventions), but

Mom better not fall!" One family member is a retired nursing home surveyor and a nurse, and is the most insistent.

A. *We are not aware of any successful legal action against a facility for not using a restraint, but there are many successful legal actions for using a restraint and using it inappropriately. The facility should involve the family representative in planning care for the resident. There is no way the facility can guarantee that the resident will not fall, even with a restraint. Assessments need to be done and appropriate support provided. If the family insists on restraining the resident, it may be that the CBRF would not be able to meet the needs of this resident and therefore should not admit/retain the person.*

26. Please speak to restraint use for the safety needs of a resident, with dementia, who may wander to stairways, etc.

A. *Restraints are not to be considered safety devices for anyone. Dementia residents who wander are in great danger if they are not adequately supervised. Restraints will agitate a resident who wanders, creating greater safety risks. Door alarms are one option to consider.*

27. Please address the use of physical intervention (as a last resort to prevent injury) when a resident is a danger to self or others.

A. *Current thinking regarding residents who are dangerous to self or others has brought us further away from the use of physical intimidation and physical intervention to prevent injuries when a resident becomes dangerous to self or others. The "old days" of frequent resident "take downs" no longer should be utilized. If you have residents for whom this kind of behavioral treatment is frequent or routine, they may not be appropriate for CBRF care. It is recommended that you consult mental health professionals and other experts in your community to provide you with up-to-date training for dealing with dangerous behaviors.*

28. Restraints - PRNs. It was stated a CBRF should be sure not to use medications as restraints. The physician prescribes medications and the CBRF carries them out. Are we being asked to go against the M.D. orders?

A. *You are not being asked to "go against" a physician's order. There is no intent on the part of the regulations to circumvent the physician. It is important that you work with the physician, the pharmacist, the resident or their legal representative to assure the appropriate use of all medications, both psychoactive medications and others. The PRN medication should be addressed in an individual service plan that outlines other interventions before giving the medication. Example: If a person is getting agitated, staff might (1) move the person to a quiet area and try to determine the cause of the agitation. (2) If this does not work staff might try decreasing the agitation by talking with or diverting the attention of the resident. (3) If this is not successful, staff might give food if the resident is hungry or direct the resident to activities if the resident is bored, etc. (4) If these interventions do not work, give the PRN medication and chart the behavior, the interventions that were tried before giving the medication, and the results of the medication.*